Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Killeen Injury Clinic

Respondent Name
Wausau Underwriters Insurance

MFDR Tracking Number
M4-14-1036-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the insurance company is delaying payment of the claims that were rendered and preauthorized."

Amount in Dispute: $170.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges for services of 09/23/2013 have been reviewed and remain denied."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2013	Physical Therapy	$170.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – This is a bundled or non covered procedure based on Medicare Guidelines. No separate payment allowed.
   - 39 – Pre-Authorization was requested but denied for this service.
   - 197 – Pre-Authorization was required by not requested.
   - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor receive prior authorization in support of medical necessity of disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.600(p) states, "Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services…" Review of the submitted documentation (Utilization Management letter dated September 18, 2013) finds the following:
    a. Submitted Code G0283 – Electrical stimulation; "…in regard to electric stimulation, the Official Disability Guidelines considers it is not recommended…" Above referenced rule also states in, (p)(12) "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier." The carrier's denial is supported as this service received an adverse authorization request.
    b. Submitted Code 97018 – Paraffin Bath; No request for authorization found in submitted documents. Carrier's denial is supported.
    c. Submitted Code A4556 – Electrodes; No request for authorization found in submitted documents. See below.
    d. Submitted Code 99082 – Travel; No request for authorization found in submitted documents. See below.
2. 28 Texas Administrative Code §134.203 (b)(1) states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; …" Per Medicare guidelines procedure code A4556 is an item or service that has no separate payment under the physician fee schedule. The carrier's denial as a bundled service is supported. The submitted code 99082 is not supported by submitted documentation. The services in dispute were reported as Place of Service "11" or office. No description of "unusual travel" was found. The carrier's denial is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.